

<b>Case Number:</b>	CM13-0062593		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	09/25/1992
<b>Decision Date:</b>	05/16/2014	<b>UR Denial Date:</b>	11/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/06/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Sports Medicine, and is licensed to practice in Texas. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 69-year-old male who reported an injury on 09/25/1992. The mechanism of injury involved repetitive lifting. The current diagnoses include lumbar strain, failed back surgery syndrome, lumbosacral radiculopathy, lumbar facet syndrome, lumbar discogenic pain, chronic pain syndrome, and leg length discrepancy. The injured worker was evaluated on 10/18/2013. The injured worker has been previously treated with physical therapy and chiropractic treatment. The injured worker reported 8/10 pain with radiation to the left lower extremity. Physical examination on that date revealed painful range of motion of the lumbar spine, positive straight leg raise, tenderness to palpation, antalgic gait, decreased sensation, and diminished strength. The treatment recommendations included continuation of current medication and authorization for physical therapy to re-establish a home exercise program.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

#### **6 PHYSICAL THERAPY VISITS WITH CONSULTATION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back-Lumbar & Thoracic, Physical Therapy (PT).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**Decision rationale:** The California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. As per the documentation submitted for review, the injured worker has previously participated in a course of physical therapy. However, there is no documentation of the previous course with evidence of objective functional improvement. Therefore, additional treatment cannot be determined as medically appropriate. As such, the request is non-certified.